



2020 Benefit Enrollment and Life Event Change Form – Medical & Dental Benefits

Statutorily Authorized Group (SAG) Employees and Temporary/Seasonal Employees (hired for less than 6 months)

A	<input type="checkbox"/> New Enrollment (check Event type)	<input type="checkbox"/> Add/Change (check Event type)	<input type="checkbox"/> Remove/Waive (check Event type)	Group Name: State of New Hampshire				
	<input type="checkbox"/> New Hire or Rehire over 1 year or Rehire less than 1 year & not ben eligible in last 12 mos <input type="checkbox"/> Rehire less than 1 year & ben eligible in last 12 mos <input type="checkbox"/> Existing PT/FT EE newly eligible for benefits <input type="checkbox"/> Loss of Other Coverage for employee <input type="checkbox"/> Return from LOA which resulted in loss of benefits <input type="checkbox"/> RIF or Recall placement within 3 years	<input type="checkbox"/> Marriage <input type="checkbox"/> Birth or Adoption/Placement <input type="checkbox"/> Court Order/Legal Guardian/QMCSO <input type="checkbox"/> Loss of Other Coverage for dep <input type="checkbox"/> Name Change/Other (specify): _____	<input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Death <input type="checkbox"/> Access to Other Coverage <input type="checkbox"/> Court Order Expired <input type="checkbox"/> Termination <input type="checkbox"/> Other (specify): _____	Employee Social Security #: _____	Employee Status: <input type="checkbox"/> SAG – BFA, CDFA, LCHIP, NHRS, Pease, SEA, or Survivors (DOT & Safety) <input type="checkbox"/> Temporary/Seasonal (hired for less than 6 months)			
				NHFIRST Employee ID #: _____	Email: _____			
B	Employee Name (PLEASE PRINT): First Name MI Last Name						Employee DOB (mm/dd/yy) _____	Home Phone: _____
	Mailing Address (PLEASE PRINT) _____ City _____ State _____ Zip Code _____							
C	First Name MI Last Name	DOB	Sex	Medical Election (choose ONE per person)	Dental Election (choose ONE per person)	<div style="margin-bottom: 10px;"> Submission Deadline: Must submit completed enrollment form and supporting documentation <i>within 45 days</i> of date of hire or status change from PT to FT or within 30 days of a qualifying life event. If you miss the submission deadline, you must wait until next Open Enrollment to enroll or make changes. </div> <div> Documentation Requirements: Newly enrolling a spouse requires a copy of state-issued marriage certificate. If marriage is over 90 days old, you must also provide ONE of the following documents dated within the last 90 days: 1) mortgage statement; 2) home equity loan statement; 3) lease agreement; 4) automobile registration; 5) credit card or account statement; 6) utility bill; 7) property tax document. Alternately, you may provide page 1 of your current Federal Income Tax Return and one of the following: a) signature page with names and signatures of employee and spouse; <u>or</u> b) email confirmation of certificate of filing listing the spouse. Newly enrolling a child requires a copy of state-issued birth certificate listing the employee as parent. Stepchild requires copy of state-issued birth certificate showing spouse as parent and marriage certificate. Adopted child requires copy of adoption paperwork or state-issued birth certificate listing employee as parent. Legal Guardian/Court Order requires state-issued birth certificate and court order signed by a judge to verify employee is legal guardian of child; QMCSO issued by a state agency to verify employee is responsible for insuring child. </div> <div> Additional Documentation Requirements For more information about deadlines and documentation requirements for Benefit Enrollments and Qualifying Life Events, including REMOVAL of dependents, go to: http://das.nh.gov/hr/documents/Benefit%20Enrollment%20Grid%20and%20Required%20Documentation.pdf </div>		
	Employee - same as above unless name change indicated here: Old Name: _____ New Name: _____	same as above	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Enroll in HMO <input type="checkbox"/> Enroll in POS <input type="checkbox"/> Waive Medical <input type="checkbox"/> No Change/Same	<input type="checkbox"/> Enroll in Dental <input type="checkbox"/> Waive Dental <input type="checkbox"/> No Change/Same			
	Spouse (First MI Last) Name: _____ SSN: _____ - _____ - _____	DOB (mm/dd/yy)	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Enroll in Medical <input type="checkbox"/> Waive Medical <input type="checkbox"/> No Change/Same	<input type="checkbox"/> Enroll in Dental <input type="checkbox"/> Waive Dental <input type="checkbox"/> No Change/Same			
	Child #1 (First MI Last) Name: _____ SSN: _____ - _____ - _____	DOB (mm/dd/yy)	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Enroll in Medical <input type="checkbox"/> Waive Medical <input type="checkbox"/> No Change/Same	<input type="checkbox"/> Enroll in Dental <input type="checkbox"/> Waive Dental <input type="checkbox"/> No Change/Same			
	Child #2 (First MI Last) Name: _____ SSN: _____ - _____ - _____	DOB (mm/dd/yy)	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Enroll in Medical <input type="checkbox"/> Waive Medical <input type="checkbox"/> No Change/Same	<input type="checkbox"/> Enroll in Dental <input type="checkbox"/> Waive Dental <input type="checkbox"/> No Change/Same			
	Special Instructions for Employee: 1) Please list additional children on a second form 2) If newly enrolling in, changing, or waiving medical and/or dental benefits, please verify that an Election is made for EACH person listed, then sign and date the Benefit Enrollment Attestation on the reverse side of this form. 3) Submit completed forms & supporting documentation to your Agency Benefit Rep (https://das.nh.gov/hr/hr-contacts.aspx) 4) Employees and their spouse/dependents cannot be enrolled in more than one SONH medical or dental plan at one time.							
D	Agency Name	Benefit Rep Name	Contact Phone	Date Sent to RMU	Date of hire, term. or life event	Benefit Start/End Date	Date NHFIRST updated	Initials

SAG/Temp Seasonal Employee Benefit Enrollment Attestation

1. **SAG Employees:** I acknowledge that deductions of the required contributions toward the cost of coverage will be automatically taken from my pay. **Temporary/Seasonal Employees:** I acknowledge that **if I elect Dental coverage, deductions for the FULL COST of the Dental benefit will be automatically taken from my pay. If I elect Medical coverage, I understand that I will be billed directly for the FULL COST of the benefit.** Failure to pay the medical premium will result in retroactive cancellation and I will be responsible for paying all claims incurred after that date. I understand that **if I waive both Medical and Dental coverage, no benefit deductions will come out of my pay** and, if applicable, my existing coverage as a spouse/child of another State employee will not be interrupted.
2. Benefit elections under the plan can be changed or revoked by me at each annual open enrollment or during the plan year on account of and consistent with a Special Enrollee and/or qualifying life event, or as otherwise permitted by federal law. Special Enrollee and/or qualifying life event changes will only be permitted if requested within the required timeframes and supported by the required documentation listed in the **Documentation Requirements for Benefit Enrollments and Disenrollments, available at: <http://das.nh.gov/hr/documents/Benefit%20Enrollment%20Grid%20and%20Required%20Documentation.pdf>**
3. I understand that benefits are governed by and subject to the conditions stated in the applicable Benefits Booklet and other governing contracts, documents and state and federal law. I further understand that plan coverage and eligibility requirements may change from time to time pursuant to changes in collective bargaining agreements and state and federal law.
4. I understand that I may enroll my legally married spouse and/or eligible dependents as outlined in the applicable Benefits Booklet and that **I will be required to provide documentation supporting the eligibility of any spouse/dependent** upon enrollment and from time to time thereafter. I understand that if I do not provide these documents within the specified timeframe, my spouse/dependent(s) will not be enrolled in health benefits and cannot be added until the next annual open enrollment period or qualified Special Enrollee and/or qualifying life event.
5. I understand that **I am required to notify my Agency HR/Payroll Representative of any changes in spouse or dependent eligibility**, such as divorce, birth, adoption, marriage, etc., that affects eligibility for benefits. I also understand that I must submit a *Benefit Enrollment and Life Event Change Form* with the required supporting documentation to my Agency HR/Payroll Representative within the timeframes set forth in the applicable Benefits Booklet. Failure to notify my Agency HR/Payroll Representative in a timely manner could result in delayed enrollment (if adding a spouse/dependent) or retroactive termination and recovery of claims (if removing a spouse/dependent) and may result in me being responsible for payment of claims.
6. I understand that **no one is allowed to be covered by more than one State of New Hampshire medical or dental plan at one time.** I understand that I am required to notify the plan immediately if I, my spouse, or dependent child(ren), enroll in another State of New Hampshire plan, to avoid duplicate coverage.
7. Privacy Act Statement: The information you provide on this form is needed to document your enrollment in the State's Health Benefit Plan. This information will be shared with health benefit vendors, including medical and dental carriers. We request you provide your Social Security Number (SSN), as Section 1502(a) of Public Law 111-148 requires employers to collect Social Security Numbers (SSNs) of individuals who are covered on their health benefit plan. The State uses this SSN and other information on this form to file forms reporting employer-sponsored health coverage to the IRS. Providing your SSN is not mandatory. However, while the law does not require you to supply all the information on this form, failure to provide the requested information may result in the State's inability to promptly process your enrollment. The Privacy Act (5 U.S.C. 552a(b)), as amended, prohibits the disclosure of information obtained by the State of New Hampshire in a system of records to third parties, unless the beneficiary provides a written request or explicit written consent/authorization for a party to receive such information. Where the plan participant provides written consent/proof of representation, the State will permit authorized parties to access requisite information. By signing this form, you are allowing the State to provide requisite information to authorized parties.
8. I understand that furnishing any misleading, deceptive, incomplete, or untrue statement and/or committing fraud or misrepresentation against the plan may result in termination of benefits for myself and or my dependent(s) either prospectively or retroactively. Retroactive termination may result in recovery of claims paid on behalf of myself or my dependent(s).
9. The information I have furnished is, to the best of my knowledge and belief, correct and complete.

Employee Name (printed): _____ Employee ID: _____

Employee Signature: _____ Date Signed: _____